OUTPATIENT DIALYSIS SERVICES PAYMENT SYSTEM

*payment***basics**

Individuals with end-stage renal disease (ESRD)—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering about 90 percent of all people with ESRD in the United States. Total Medicare spending for these beneficiaries has exceeded original spending projections—reaching about $17 billion in 2003—primarily because of unanticipated growth in the ESRD population. The nearly 400,000 enrolled ESRD beneficiaries in 2003 accounted for about 1 percent of total Medicare enrollment, compared with only 0.1 percent of enrollment in 1974. This enrollment growth reflects population aging, increased prevalence of diabetes—a major risk factor for ESRD—and improvements in clinical knowledge and technique that have enabled successful treatment of older patients and those with coexisting illnesses who might not have been treated 30 years ago.

Because of the scarcity of kidneys available for transplantation, most people with ESRD (72 percent) receive maintenance dialysis. Medicare spending for outpatient dialysis and injectable drugs administered during dialysis (about $7 billion in 2003) accounts for 2 percent of total program expenditures but is a predominant share of revenues for dialysis facilities. Medicare pays dialysis facilities a predetermined payment for each dialysis treatment they furnish, using a payment system first implemented in 1983. The prospective payment—called the composite rate—is intended to cover the bundle of services, tests, certain drugs, and supplies routinely required for dialysis treatment and is adjusted to account for differences in case mix and local input prices.

Technological advances have changed the provision of dialysis care since the composite rate was established. Consequently, the composite rate currently excludes several injectable drugs—such as erythropoietin, vitamin D, and iron—that have diffused widely into medical practice over the past decade. Providers are paid separately for these services, and in 2003, drugs comprised about 40 percent of facilities' Medicare payments. Beneficiaries pay a 20 percent copayment for both composite rate services and separately billable drugs.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and regulations that the Centers for Medicare & Medicaid Services (CMS) issued to implement the new law changed how Medicare pays for injectable drugs and dialysis treatments by:

- paying acquisition cost for all separately billable injectable drugs;
- shifting some of the profits previously associated with payments for separately billable drugs through an add-on payment to the composite rate; and
- adjusting the composite rate for differences in case mix.

However, the MMA does not change the basic structure of the dialysis payment system—separate payments for dialysis treatments and injectable drugs.

Defining the care that Medicare buys

Medicare covers two methods of dialysis—hemodialysis and peritoneal dialysis. In hemodialysis, a patient's blood is cycled through a dialysis machine, which filters out body waste. More than 90 percent of all dialysis patients undergo hemodialysis

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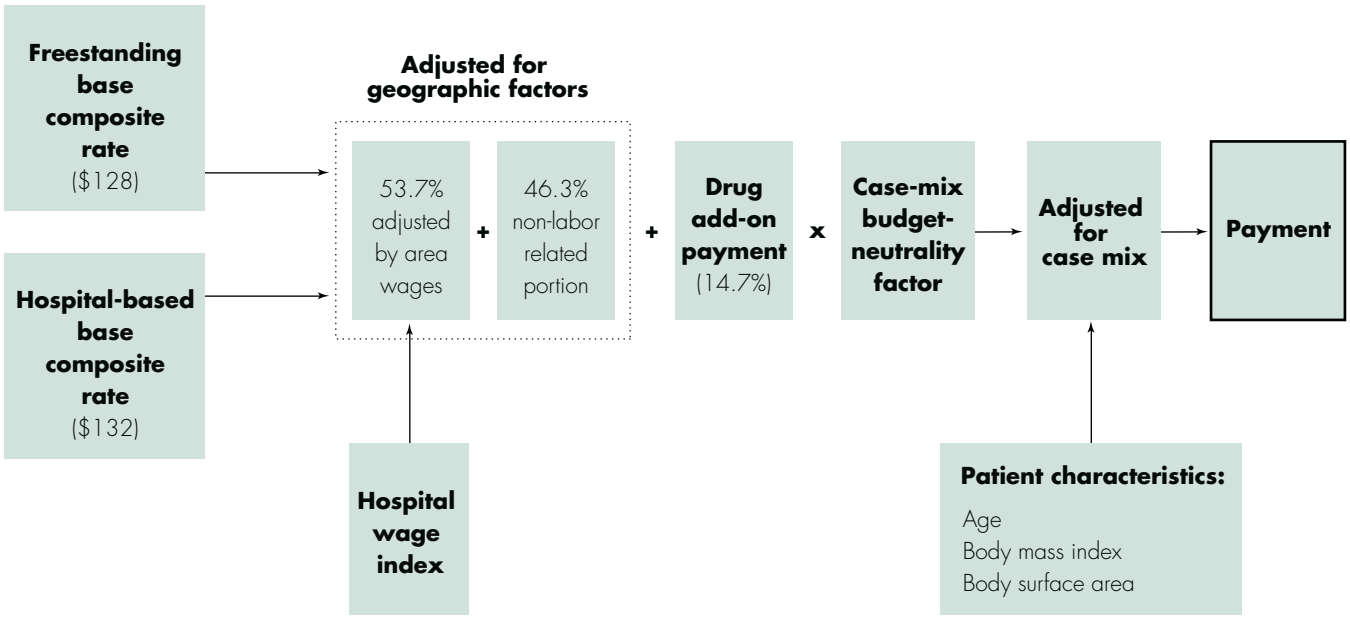
Figure 1 Dialysis prospective payment system in 2006



Note: Dialysis facilities are paid separately for furnishing certain injectable drugs. In 2003, these payments accounted for about 40% of all payments to dialysis facilities. In addition, providers furnishing laboratory tests outside the composite rate bundle are paid separately according to the laboratory fee schedule.

three times per week in dialysis facilities. Peritoneal dialysis uses the membrane lining or the peritoneal cavity to filter excess waste products, which are then drained from the abdomen. Patients undergo peritoneal dialysis five to seven times per week in their homes.

The unit of payment is the dialysis treatment. The composite rate payment system differs from most other prospective payment systems because it uses only one product category to define the service bundle Medicare is buying. Although different equipment, supplies, and labor are needed for hemodialysis and peritoneal dialysis, the current system does not differentiate payment based on dialysis method.

Providers separately bill Medicare for certain injectable medications, including erythropoietin and vitamin D analogs, and laboratory tests that are not included in the composite rate bundle.

For dialysis drugs, Medicare pays freestanding and hospital-based providers using average sales price. This method uses prices that manufacturers report to CMS every quarter. CMS set the 2006 rates for these drugs at average sales price (ASP) plus 6 percent.

Finally, providers furnishing laboratory services outside the composite rate bundle are paid according to the laboratory fee schedule.

Setting the payment rates

The composite rate is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. The base payment rate is $132 for hospital-based facilities and $128 for freestanding facilities in 2006 (Figure 1). Medicare caps its payments to facilities at an amount equal to three dialysis sessions per week, although home dialysis may be given more frequently.

Beginning in 2005, the MMA changed the composite rate in two ways. First, the new law shifted some of the profits previously associated with payments for separately billable drugs through an add-on payment to the composite rate. The Secretary is required to annually update the add-on payment to account for the growth in separately billable drugs beginning in 2006 that would have occurred if pre-MMA payment policies still applied. CMS calculated an update factor of 1.4 percent and a total add-on payment of 14.7 percent for both hospital-based and freestanding facilities in 2006. Second, the new law called for the composite rate and the add-on payment to be adjusted for case mix. The case-mix measures that CMS has used since April 2005 are:

- age (<18, 18–44, 45–59, 60–69, 70–79, ≥80 years), and
- two body measurement variables—body surface area and body mass index.

In the MMA, the Congress gave the Secretary the authority to revise the wage index that the Secretary currently uses in the dialysis payment system. CMS modernized the geographic classification areas and indexes used to account for differences in local input prices beginning in 2006 by:

- using Office of Management and Budget's newly defined geographic areas known as Core-Based Statistical Areas, and
- recalculating the ESRD wage indexes based on acute care hospital wage and employment data for fiscal year 2002.

In addition, CMS updated the labor portion of the ESRD composite rate to which the wage index is applied. The labor-related portion of the composite rate is 53.7 percent for both freestanding and hospital-based providers in 2006. Finally, CMS intends to eliminate the geographic payment adjustors used by the previous wage index method.

Other MMA changes to the dialysis payment system

The new law restored special payment provisions for pediatric facilities providing dialysis under certain circumstances beginning in 2005. The Secretary is required to report on the design of a broader bundled payment system that includes injectable drugs, laboratory tests, and other items currently excluded from the outpatient dialysis bundle. The report will consider potential services to be included, methods to establish and update payment rates, and adjustments for patient mix, geography, and rural facilities. Based on this report, in 2006 the Secretary is required to begin a three-year demonstration of a broader payment bundle that includes all injectable drugs and laboratory tests. ■